



Last Updated: 03/09/2022

## Changes to the Review Process for Treatment Foster Care-Case Management Services - Effective December 15, 2004

The purpose of this memo is to inform you of changes to the Medicaid-funded Treatment Foster Care-Case Management (TFC-CM) Services review process. The changes being made are in response to provider and locality representative requests for a less cumbersome authorization process. Although this memo contains a large amount of information, the brief overview of each required form is not new information, but rather a reminder of what information is required on each form. It is anticipated that use of the revised WVMi (West Virginia Medical Institute) review forms, deletion of the Care In Progress form, and provision of sample forms will reduce the need to pend requests for additional information, resulting in timelier decisions rendered.

As you are aware, a pre-authorization request for Medicaid-reimbursed TFC-CM services is to be submitted to WVMi on an Initial Review form within 10 days of the admission. Subsequent reviews are due no later than the last day of the current authorization. DMAS staff has worked with providers to develop a process that is more user-friendly and is expected to reduce the number of pended pre-authorization requests. The following three changes will go into effect on December 15, 2004, to help streamline the pre-authorization process. In addition, this memo outlines the information that must be part of the WVMi submission to facilitate a timely turnaround by WVMi and prevent the pending of requests.

### **PROGRAM CHANGES**

1. DMAS has revised the WVMi review forms and deleted information that may already be found on forms in use at your facility that meet federal, state, and licensing regulations. These revised forms must be submitted to WVMi for pre-authorization purposes. The length of approval is based on the medical necessity documentation.



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Requests could be approved for as much as six months. If, for example, a discharge date were noted for 60 days from the submission of the review, WVMi would only approve up to 60 days.

2. The Care In Progress form will no longer be required. An initial review is required for a child in placement for up to 45 days. If the child has been in placement for more than 45 days, the Continued Stay form is required. Retroactive authorization is only available in the case of retroactive recipient Medicaid eligibility, and the additional information noted in item 2 of the review form will also be required.
3. In order to provide you with an outline for proper documentation, DMAS has developed the attached sample forms. You are not required to use these forms; however, use of the forms, along with proper documentation, will provide WVMi with the information they need to more efficiently review your request. These forms are the FAPT (Family Assessment and Planning Team) Assessment and a 30-day Narrative & Progress Update. Also noted below is a brief overview of the required 90-day Progress Report.

The revised WVMi forms and sample forms will be available on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov), as well as available from Commonwealth-Martin by calling the DMAS Order Desk at 804-780-0076.

## **FAPT ASSESSMENT**

The following is a brief overview of the minimum information required in the FAPT Assessment form. The provided information should reflect the locality's assessment and plan for the child. Any format is acceptable, as long as it includes the following information:



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- Immediate and long-range therapeutic needs;
- Developmental priorities;
- Personal strengths and liabilities;
- Potential for reunification;
- Treatment objectives and modalities; and
- Dated signatures of at least three FAPT members.

## 30. DAY NARRATIVE & PROGRESS UPDATE

As you are aware, a 90-day Progress Report, current within 30 days, must be submitted to WVMI for pre-authorization purposes. If the 90-day Progress Report does not cover any of the 30 days prior to the authorization request date, then a 30-day Narrative & Progress Update will be required. The following is a brief overview of some of the required elements for the 30-day Narrative & Progress Update:

- The 30-day Narrative & Progress Update must be current, within 30 days of submission of an authorization request. This form is not necessary if the 90-day Progress Report is current, within 30 days of submission of the authorization request.
- Note any changes to the diagnosis, treatment goals, medications, treatment interventions, and discharge plans since the last 90-day Progress Report.
- If the current problem behaviors are not documented on the Child and Adolescent Functional Assessment Scale (CAFAS), it needs to be updated.

## 90. DAY PROGRESS REPORT



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The following is a brief overview of some of the required information for the 90-day Progress Report. The following items have been identified as areas that are often insufficiently documented and lead to pends and denials:

- Note the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each. Be sure to address the therapeutic goals, rather than just age-appropriate activities of daily living. Address the reasons for this level of care.
- Note descriptions of therapies, activities, and services provided during the previous 90 days that facilitated progress toward treatment goals and objectives.
- Describe the need for continued care. Be child-specific. Describe the continuing problems or any new problems that have arisen. This description should reflect the CAFAS scores. If not, the CAFAS may need to be re-scored to reflect current problem behaviors.
- Be sure the discharge plan is specific or, if this is not possible at this time, explain why not. The discharge plan should relate to the child no longer requiring this intensive level of daily case management, but not necessarily to discharge from the treatment foster care home.
- Address any discrepancies between the CAFAS scores and the reasons for the continued need for this level of care. The CAFAS scores should be updated if they do not reflect current behavior. The CAFAS scores must include individual scores for all scales, including Caregiver scales. There must be a minimum of one moderate impairment in a role performance area other than school.

### **MEDICAL DOCUMENTATION**

All documentation must be signed and dated at the same time. Dates should not be



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typed onto medical records in advance of the signature. A dictated treatment plan is not considered complete until the plan is signed and dated by the required professional and is available in the medical record.

Please note that, if a request is pended, WVMi will only be able to approve the request from the date that all required information is received by WVMi. The WVMi pend notice that indicates the deadline for submitting the missing information does not mean the provider has additional time to submit the information. Approval will not be retroactive. Authorization requests must be complete and timely to prevent denial of services.

## **CONTACT INFORMATION**

If you have questions concerning any of the information in this memo, please contact Shelley Jones, DMAS Contract Monitor, at 804-786-1591.

If you have questions about review requests, please call or fax WVMi using the following numbers:

Phone:

804-648-3159

Richmond area

800-299-9864

All other areas (toll-free)

Fax:

804-343-9782

Richmond area

800-439-9295

All other areas (toll-free)



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## ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

## COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH Provider Manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

## "HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (toll-free, in-state long distance)



Department of Medical Assistance Services  
600 East Broad Street  
Suite 1300  
Richmond, VA 23219

<https://dmas.virginia.gov>

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Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.